



2017 Community  
Benefits Report

---

2018 Community  
Benefits Plan

 **Stanford**  
HEALTH CARE  
STANFORD MEDICINE

**ValleyCare**



January 22, 2018

Mr. Kyle Rowert  
Office of Statewide Health Planning and Development  
Healthcare Information Division  
Accounting and Reporting Systems Section  
400 R Street, Suite 250  
Sacramento, CA 95811

Mr. Rowert:

We are pleased to submit the annual Community Benefits Report for Stanford Health Care-ValleyCare (SHC-VC). This report covers our fiscal year 2017 for the period September 1, 2016–August 31, 2017. Along with the report you will find a Community Benefits Plan for our fiscal year 2018 for the period September 1, 2017–August 31, 2018.

If you have any questions, please contact Denise Bouillercer, Director of Marketing/Public Relations at 925.373.4020 or via email [dbouille@stanfordhealthcare.org](mailto:dbouille@stanfordhealthcare.org).

Sincerely,



Scott Gregerson, Esq.  
President  
Stanford Health Care-ValleyCare

1111 E. Stanley Boulevard | Livermore, CA 94550 (mailing address)  
5555 W. Las Positas Boulevard | Pleasanton, CA 94588



## TABLE OF CONTENTS

### STANFORD HEALTH CARE-VALLEYCARE: FISCAL YEAR 2017 COMMUNITY BENEFITS REPORT

<b>I.</b>	<b>Introduction .....</b>	<b>4</b>
<b>II.</b>	<b>Community Served.....</b>	<b>5</b>
<b>III.</b>	<b>Community Benefit Goals &amp; Objectives.....</b>	<b>6</b>
	A. Health Care Access & Delivery .....	6
	B. Behavioral Health .....	6
	C. Obesity, Diabetes, Healthy Eating, Active Living .....	6
<b>IV.</b>	<b>Summary of Community Benefit Investments.....</b>	<b>6</b>
	A. Category 1: Benefits for Vulnerable Populations .....	7
	B. Category 2: Benefits for the Broader Community .....	9
	C. Category 3: Health Research, Education, & Training .....	12

### STANFORD HEALTH CARE-VALLEYCARE: FISCAL YEAR 2018 COMMUNITY BENEFITS PLAN

<b>I.</b>	<b>Community Benefit Plan Goals &amp; Strategies.....</b>	<b>14</b>
	A. Health Care Access & Delivery .....	14
	B. Behavioral Health .....	16
	C. Obesity, Diabetes, Healthy Eating, Active Living .....	19
<b>II.</b>	<b>Evaluation Plans .....</b>	<b>21</b>
	<b>Endnotes .....</b>	<b>22</b>

## STANFORD HEALTH CARE-VALLEYCARE: FISCAL YEAR 2017 COMMUNITY BENEFIT REPORT

### I. INTRODUCTION

Stanford Health Care-ValleyCare (SHC-VC) has been dedicated to providing high-quality, nonprofit health care to the Tri-Valley and surrounding communities since 1961. Through highly skilled physicians, nurses, and staff, and state-of-the-art technology, SHC-VC provides a wide range of health care services at its Livermore, Pleasanton, and Dublin medical facilities. SHC-VC has a total of 242 beds and a medical staff of approximately 500, offering an array of inpatient and outpatient services to the community. On May 18, 2015, ValleyCare affiliated with Stanford Health Care, and Stanford Health Care became the sole corporate member of SHC-VC.

Under SB 697, the state of California requires all nonprofit hospitals in California to complete and submit an annual Community Benefit Report. Although hospitals bring numerous benefits to their local economies, these reports document the ways in which each hospital goes above and beyond its core functions to support the health needs of its community. Every three years, nonprofit hospitals in California must conduct a community health needs assessment (CHNA) to identify the greatest health needs affecting their respective communities. In addition to the state mandate, the federal Patient Protection and Affordable Care Act, enacted March 23, 2010, requires tax-exempt hospitals to conduct CHNAs and to adopt implementation strategies to meet the health needs identified through the assessments.

SHC-VC collaborated with Kaiser Foundation Hospitals in Antioch, Fremont, Oakland, Richmond, San Leandro, and Walnut Creek, as well as John Muir Health, St. Rose Hospital, San Ramon Regional Medical Center, UCSF Benioff Children's Hospital Oakland, and Washington Hospital Healthcare System, in the 2016 CHNA process. The process built on the 2013 CHNA and included a comprehensive review of secondary data on health outcomes, drivers, conditions, and behaviors, as well as collection and analysis of primary data through interviews with local experts and community conversations with representative members of vulnerable populations in our service area. Public and community health leaders, advocates, and experts convened to provide input on the identified community health needs and the relative priority of each need. The resulting prioritized list represents a community understanding that is informed by both data and experience.

As a community-based organization, SHC-VC understands the value of continuously assessing the health needs of the community it serves. By doing so, we are able to establish a systematic process for identifying community health needs that will guide thoughtful and effective community investment for years to come.

**Mission Statement:** To care, to educate, to discover.

**Vision:** Healing humanity through science and compassion, one patient at a time.

## II. COMMUNITY SERVED

SHC-VC's primary service area is the Tri-Valley. The Tri-Valley region is based around the four suburban cities of Livermore, Pleasanton, Dublin, and San Ramon in the three valleys from which it takes its name: Amador Valley, Livermore Valley, and San Ramon Valley. Livermore, Pleasanton, and Dublin are in Alameda County, while San Ramon is in Contra Costa County.

SHC-VC has facilities in Pleasanton, Livermore, and Dublin. The Tri-Valley accounts for the majority of SHC-VC's inpatient discharges.

*Figure 1. SHC-VC Service Area Map*



### III. COMMUNITY BENEFIT GOALS & OBJECTIVES

For the fiscal year 2017 from September 1, 2016-August 31, 2017 (FY17), SHC-VC's goals for its Community Benefits Plan were:

#### A. Health Care Access & Delivery

**Long-Term Goal: Increase number of Tri-Valley area residents who have access to appropriate health care services.**

**Intermediate Goal:**

- Improve access to quality primary and specialty care and preventive health care services for at-risk community members.

#### B. Behavioral Health

**Long-Term Goal: Improve behavioral health among residents in the Tri-Valley area.**

**Intermediate Goals:**

- Improve mental health and well-being among residents.
- Improve residents' access to coordinated mental health care.
- Reduce drug and alcohol use among residents.

#### C. Obesity, Diabetes, Healthy Eating, Active Living

**Long-Term Goal: Increase healthy behaviors among children, youth, and adults in the Tri-Valley area to manage, reduce, or prevent obesity and diabetes.**

**Intermediate Goals:**

- Increase healthy eating and active living among children, youth, and adults in the Tri-Valley area.
- Improve diabetes management among adults in the Tri-Valley area.

### IV. SUMMARY OF COMMUNITY BENEFITS INVESTMENTS

For the purposes of this report, the above SHC-VC activities fall into three major categories:

1. Benefits for vulnerable populations
2. Benefits to the broader community
3. Health research, education, and training programs

The table below summarizes the SHC-VC FY17 (September 1, 2016–August 31, 2017) investment in community benefit.

*Table 1. SHC-VC Investment in Community Benefits, FY17*

<b>Community Benefit</b>	<b>Amount</b>
Charity Discounts	<b>\$1,771,165</b>
Benefits for Vulnerable Populations	<b>\$608,658</b>
Medi-Cal (Uncompensated Expense)	<b>\$25,273,692</b>
Medicare (Uncompensated Expense)	<b>\$38,373,583</b>
Benefits for the Broader Community	<b>\$752,465</b>
Health Research, Education, and Training	<b>\$1,917,534</b>
Total Excluding Uncompensated Expense of Medicare	<b>\$30,323,514</b>
Total Including Uncompensated Expense of Medicare	<b>\$68,697,097</b>

## **A. Category 1: Benefits for Vulnerable Populations**

### **Investments in Vulnerable Populations**

In addition to investments in charity care and uncompensated Medi-Cal, SHC-VC's contribution to other community benefit activities for vulnerable populations was \$608,658 in FY17.

### **Activities for Vulnerable Populations**

As part of SHC-VC's support for its community partners and other community-based agencies, in FY17 SHC-VC conducted a variety of activities for community members, including education and support to persons with chronic conditions, meals to the disabled and seniors, and reduced-cost wellness programs for economically disadvantaged members of the community. These activities provided essential services for those most in need in our communities.

SHC-VC actively participated in the **Tri-Valley Health Initiative**. This initiative serves as a gateway to make contact and engage with under-served communities, and to provide health screenings, linkages, and health care enrollment opportunities to youth and families in the Tri-Valley. The initiative aims to increase access to health care for youth and families, including culturally-relevant prevention services, and strengthens the continuum of school-linked health supports throughout the Tri-Valley. Also, the initiative provides further

opportunity to collaborate with school health officials in the local school districts regarding ongoing health concerns such as asthma and behavioral health.

In FY17, SHC-VC was also active in the **Tri-Valley Anti-Poverty Collaborative**. This collective impact initiative to end poverty in the Tri-Valley area involves partners from government, nonprofits, faith-based organizations, schools, philanthropic organizations, businesses, and individual community residents. The Tri-Valley Anti-Poverty Collaborative supports a community in which struggling residents across the region can achieve a basic standard of living in housing, health care, nourishment, education, and sustainable financial resources.

Throughout FY17, SHC-VC provided **Open Heart Kitchen** with space on its Livermore campus free of charge. The local nonprofit organization, which serves free meals to the hungry, stored food and assembled box lunches in this space.

For incoming residents of the **Tri-Valley Haven** shelter, SHC-VC offered TB screening tests and provided initial patient evaluation and follow-up diagnostic testing for any positive TB tests at no charge. SHC-VC provided 92 TB tests during the reporting period. In addition, SHC-VC gave 204 turkeys to the shelter over the Thanksgiving holiday.

LifeStyleRx is SHC-VC's 70,000-square-foot wellness center providing comprehensive, medical-based, high-quality education and fitness services to all community members. The **LifeStyleRx Scholarship Program** provides low-income members of the community the opportunity to achieve their maximum health, fitness, and well-being potential by providing scholarships for membership. During the reporting period, the Scholarship Program provided 18 LifeStyleRx memberships to low-income members of the community.

**Marilyn Avenue Elementary School** in Livermore had limited funding to support a physical education (PE) program. SHC-VC funded a PE program, which allowed for an instructor to conduct PE classes during the school week for students. This project focused on improving scores for state testing, improving the students' physical health, and educating the students on healthy living and how to use exercise as a tool to help with focus in the classroom. Twice a week over the course of 28 weeks, students in three classes received 75 minutes of physical education. Overall, 80% of the 66 Marilyn Avenue fifth-graders who participated in physical education in 2016-2017 improved on at least two of three physical fitness tests. Teachers reported that students had better behavior, were more focused, and exhibited better teamwork with others in their classrooms over the course of the school year. Also at Further, SHC-VC supported the provision of an educational workshop for Spanish-speaking parents about enhancing their kindergarteners' success in school, and provided written resources (e.g., handouts about sleep, literacy, cooking, and age-appropriate development) and fresh produce for 100 families. Finally, SHC-VC staff provided education on healthy eating and physical activity at the Marilyn Avenue Elementary School **Health and Nutrition Fair**, which had over 100 attendees.



For **Meals on Wheels**, SHC-VC prepared more than 900 meals a day, five days a week for homebound seniors in seven Alameda County cities, including Pleasanton, Livermore, Dublin and Sunol. These hot meal programs provide local seniors with the healthy nutrition they need that is critical to their health and well-being. SHC-VC also provided office space to Spectrum, the nonprofit organization in charge of organizing the Meals on Wheels program in the Tri-Valley area.

SHC-VC has a data-sharing collaboration with **Alameda Alliance** to ensure that pediatric patients with asthma are offered educational and case management supports. In FY17, SHC-VC ran periodic reports to identify any Alliance pediatric members who had an asthma-related emergency department (ED) visit. These pediatric patients with asthma made fewer ED and inpatient visits after the start of the program than before, and substantially fewer than a control group.

SHC-VC also provided experts to assist uninsured, low-income patients to research health care options. Services provided by **MedData** (formerly **Diversified Healthcare Resources**), at no cost, included helping individuals research eligibility requirements, identify appropriate health insurance programs, complete applications, compile required documentation, and follow up with county case managers. This service assists eligible patients in obtaining coverage for medical necessities such as hospital care, prescription drugs, and home health care.

Finally, SHC-VC provided funds for a licensed Marriage and Family Therapist (MFT) for **Axis Community Health**. This individual will increase capacity to serve an additional 25-30 Tri-Valley residents per week at Axis' clinical site. As we move into FY18, this added mental health counseling service capacity will help to alleviate the dire need for more services in the community and will serve as a referral option for patients who present with a non-acute mental health condition, such as anxiety or depression, while seeking care at SHC-VC's emergency department.

## **B. Category 2: Benefits for the Broader Community**

### **Investments in the Broader Community**

SHC-VC supports a wide range of activities that benefit the broader community. SHC-VC contributed \$752,465 in FY17 to support these activities.

### **Activities for the Broader Community**

Through its **Cancer Programs**, SHC-VC offered education, awareness-building, and cancer support groups for the community.

- In its Yoga for Cancer Program, SHC-VC provided a community support group that teaches yoga to those suffering from cancer and to their families.

- The SHC-VC Healing Touch Program ensured that each person in the community receiving cancer treatment was offered supportive care implementing Healing Touch techniques to support the person as a whole and to manage symptoms of pain, malaise, nausea, and/or stress.
- SHC-VC hosted a free, educational Breast Cancer Symposium open to anyone concerned about the following topics: breast cancer and the latest, cutting-edge treatments, fertility preservation during breast cancer therapy, value and quality in breast cancer treatment, and breast cancer genetics and genomics.
- SHC-VC offered seminars on breast cancer-related lymphedema, including causes, signs, symptoms, risk-reduction, and treatment options, including physical therapy.
- SHC-VC offered the Look Good Feel Better Program, a support group for women dealing with the side effects of cancer treatment. Through this program, specially trained volunteers teach self-care, beauty, and psychological support, provide wigs and scarves, and conduct demonstrations for coping with hair loss.

SHC-VC provided funding to the following organizations fighting cancer:

- The Sandra J. Wing Healing Therapies Foundation to provide cancer patients, during their treatment period, with financial assistance for complementary healing services such as acupuncture, acupressure, therapeutic massage, guided/visual imagery, and deep breathing meditation.
- The HERS Breast Cancer Foundation to provide support for women healing from breast cancer by providing post-surgical products and services, regardless of financial status.
- A 24-hour walk event (Relay for Life) for cancer awareness and fundraising in support of the American Cancer Society. At this event, SHC-VC provided education about lung cancer, including education on prevention and early detection.

SHC-VC provided a wide variety of resources and services to the broader community regarding **cardiac information and education**.

The SHC-VC **My Heart's Content Program** provided lectures to the community on cardiovascular health.

The SHC-VC **American Heart Association Training Center** conducted classes throughout the year, teaching community members cardiopulmonary resuscitation (CPR) and providing them with American Heart Association cards as proof of CPR certification. Also, SHC-VC's educators taught "hands only CPR" to community members during community events. "Hands only CPR" is an American Heart Association initiative to teach community members CPR through a hands-only approach.

The **Infant CPR Program** provided CPR training to the community at large, and was also offered free to low-income parents of newborns.

SHC-VC held **maternal and child education classes** to prepare parents for childbirth. These classes were offered to the community at large and were free to low-income parents. SHC-VC also sponsored a class to help siblings adjust to a new baby. In addition, SHC-VC provided education for new mothers on the benefits and importance of breastfeeding their infants. The New Moms Support Group supported new mothers with guest speakers who focused on breastfeeding as a healthy start to life. The SHC-VC New Mom Wellness Program offered by LifeStyleRx was an effective way for new mothers in the community to increase their fitness and feel better while coping with a new baby. This comprehensive four-week program taught methods of gaining energy, living a healthy lifestyle, and becoming motivated to take care of newly-expanded families.

In FY17, the **SHC-VC Health Library** provided scientifically based health information to assist community members in making more informed decisions about their health and health care. The health library is open to the community and reaches out to the local population, as well as to anyone who uses the Internet. The library has an extensive collection of online health and wellness resources, including medical websites and full-text articles. It also includes conventional health and wellness resources such as books, medical journals, periodicals, and videos. All informational and educational materials are available in English and Spanish.

As obesity is a major health issue in the Tri-Valley area, **obesity and fitness education and prevention** is a top focus for SHC-VC. More than 36% of Latino fifth-graders in the Dublin School District and nearly 20% of Latino fifth-graders in the Livermore School District are overweight. SHC-VC conducted a wide variety of programs on healthy eating and physical fitness for both the broader community and for vulnerable communities.

SHC-VC provided funding to Valley View Elementary School in Pleasanton to fund needed **equipment for physical education**.

SHC-VC provided **medical supplies and first aid** to a wide variety of local community events, such as races, parades, festivals, and athletic events.

For those with diabetes, SHC-VC offered a monthly **diabetes support group** with occasional guest speakers. Additionally, SHC-VC held the annual Diabetes Education Seminar to educate Tri-Valley community members about healthy eating habits and prevention of pre-diabetes.

SHC-VC staff conducted free **balance testing**, explained results, and gave a presentation about **fall risk factors and prevention** for Pleasanton Senior Support Services, open to the community. A total of 30 seniors attended.

## **C. Category 3: Health Research, Education, & Training**

### **Investments in Health Research, Education, & Training**

SHC-VC has invested to support health research, education, and training in a wide variety of programs. SHC-VC invested \$1,917,534 in FY17.

### **Activities in Health Research, Education, & Training**

#### ***Specialized Health Care Workforce Training***

In the Health Care Administration Internship Program, SHC-VC staff supervised 41 students in all areas of the hospital as they learned and performed professional and technical tasks. Student interns rotated through various hospital units with staff and administration/management so that they could experience all dimensions of the hospital operation.

SHC-VC provided clinical experience and preceptors for graduate nursing students. Students received exposure to and experience in nurse practitioner, nursing administration, and clinical nurse specialist positions. SHC-VC registered nurses in multiple nursing units, including medical/surgical and Intensive Care Units, provided direct supervision in a clinical environment to student nurses connected with Chabot College, Samuel Merritt University School of Nursing, and California State University East Bay. Approximately 158 students participated during the reporting period.

SHC-VC provided clinical experience for emergency medical technician (EMT) students from Las Positas College, supervised by appropriate clinical personnel. One student participated during the reporting period.

SHC-VC provided surgical technology (ST) training for ST students in the operating room, supervised by a surgical technologist and registered nurses. Three students participated during the reporting period.

SHC-VC provided education for three students from Las Positas College, California State University Sacramento, and Northern California Training Institute (NCTI) who were training to become paramedics.

Throughout the year, SHC-VC hosted 13 college student interns in physical and occupational therapy in varying affiliation periods. Students received on-the-job instruction and hands-on treatment skills in the inpatient and/or outpatient setting in order to meet the requirements for their degrees and licensure.

SHC-VC provided high school Regional Occupation Program (ROP) students with valuable training, helping them to develop practical patient assessment and assistance skills. Students were permitted to observe and shadow health care staff in various areas of the hospital during a typical work day and, when appropriate, assist with simple projects for a

hands-on experience. A total of 47 high school ROP students participated during the reporting period.

SHC-VC's Medical Explorers program invited students from middle school, high school, and junior college to learn more about the field of medicine. A different speaker each month talked to the students about their specific field, about education needed, gave advice, answered questions, and shared what they know about the profession. During the reporting period, the program served approximately 350 students.



## STANFORD HEALTH CARE-VALLEYCARE: FISCAL YEAR 2018 COMMUNITY BENEFITS PLAN

### I. COMMUNITY BENEFITS PLAN GOALS & STRATEGIES

SHC-VC plans to invest its community benefit efforts, including grants, sponsorships, in-kind support, and collaboration/partnership activities, in work that benefits the larger community, including health research, health education and training, serving vulnerable populations, charity care, and unreimbursed Medi-Cal and Medicare. These activities provide essential services for those in need in the community. For FY18, SHC-VC's goals and strategies for its Community Benefit Plan are as follows:

#### A. Health Care Access & Delivery

In Alameda County, the proportion of residents that reported a delay or difficulty in obtaining care is well above the HP2020 objective. In addition, Alameda County does not meet the HP2020 objective for people with a usual source of care. Stark ethnic disparities exist in the uninsured population of the Tri-Valley/central Contra Costa County area (TV/CCC). The ValleyCare Service Area (VCSA) falls short of the state benchmark for the rate of Federally Qualified Health Centers. The community shared concerns about many aspects of health care access and delivery, including difficulties with navigating the complex health system, difficulties obtaining timely appointments with professionals (due to a perceived lack of clinical providers—especially those that accept Medi-Cal), the need for cultural competence of all health system staff, and difficulties with affording and accessing public transportation. While the CHNA identified oral health as a separate health need, the data suggest that oral health is a need in the community due to issues of access. This Health Care Access & Delivery need, which includes access to primary care and specialty care, specifically includes oral health.

**Long-Term Goal: Increase number of Tri-Valley area residents who have access to appropriate health care services.**

**Intermediate Goal A.1: Improve access to quality primary and specialty care and preventive health care services for at-risk community members.**

#### Goal A.1 Strategies:

Allocate resources to support:

- Participation in government-sponsored programs for low-income individuals (i.e., Medi-Cal Managed Care).
- Provision of Charity Care to ensure low-income individuals obtain needed medical services.

Provide grants, sponsorships, or in-kind support to community health centers, clinics, or Federally Qualified Health Centers (FQHCs) (e.g., Axis Community Health) for efforts such as:

- Providing information and opportunities for students to learn more about health care professions (e.g., the high school ROP program, the School Outreach/Medical Explorers Program, surgery simulation program for Advanced Placement high school students).<sup>1,2</sup>
- Providing support for those enrolled in an educational program by providing the setting in which specialized health care workers are trained (e.g., Dietetics Internship Program, Preceptorship program for registered nurses, nursing graduate students' mentorship program, surgical technology students' training, physical and sports medicine college student internships).<sup>2</sup>
- Chronic disease self-management interventions in community gathering places, including specific programs such as Chronic Disease Self-Management Program (CDSMP), a behaviorally-oriented program that teaches participants how to manage their chronic conditions and helps them develop confidence in managing their health.<sup>3</sup>
- The SHC-VC Health Library and Resource Center, accessible to all community members free of charge.<sup>4</sup>
- Building the capacity of local community-based clinics to provide primary and preventive health care services by providing funding and other resources.<sup>2</sup>
- Supporting trained care coordinators to facilitate health care access for underserved residents.<sup>5</sup>
- Providing medical supplies for first aid to local community events, and providing treatment for athletic injuries at youth sporting events.
- Providing free TB screenings at SHC-VC Urgent Care to incoming residents of local homeless shelters (e.g., Tri-Valley Haven and Shepherd's Gate), including imaging services if needed to assist in screening for disease.<sup>6</sup>
- Improving access to oral health care for low-income residents, e.g., by expanding the oral health safety net.<sup>7</sup>
- Supporting wellness strategies such as health fairs.<sup>8</sup>
- Supporting trained community health workers (e.g., educators) to provide one-on-one or group health education and social support for various health practices, including oral health, chronic disease self-management, and behavior change;<sup>9</sup> for example:
  - Prenatal breastfeeding education in small groups for expectant mothers.<sup>10</sup>
  - Asthma self-management education, including the role of medications, appropriate inhaler technique, identification of triggers, how to handle signs of worsening asthma, and when to seek care.<sup>11</sup>
  - Educational events open to the public regarding breast cancer.<sup>12</sup>
  - Cancer survivorship education and activities, including psychosocial support.<sup>13</sup>
  - Oral health education aimed at improving knowledge and changing oral health practices.<sup>14</sup>

- Stroke awareness and prevention education.<sup>15</sup>
- CPR classes provided in the community.<sup>16</sup>

**Goal A.1 Anticipated Impact:**

- ◆ Increased access to health care and health care services.
- ◆ Increased health care workforce pipeline.

**B. Behavioral Health**

Although the rate of death due to intentional self-harm (suicide) in the VCSA is lower than the state average, the suicide rate in TV/CCC for Whites is exponentially higher than the rate for Native Hawaiians/Pacific Islanders. However, White adults are also much less likely to report a need for mental health care as compared to other racial and ethnic groups. Severe mental illness ED visits are higher in Alameda County than in the state. The rate of binge drinking in the VCSA is higher than in Contra Costa County and the state. Also, VCSA residents' total household expenditures towards alcohol are slightly higher than the state average. The age-adjusted rate of substance abuse-related emergency department visits is higher in Alameda County than in the state overall, with stark ethnic disparities apparent (for Blacks, Native Americans/Alaskan Natives, and Whites). Providers who participated in the CHNA are seeing an increase in drug use (especially marijuana and opiates). The community expressed concern about the lack of insurance benefits for mental health issues, especially for things like stress and depression. CHNA participants also discussed the difficulty in accessing mental health specialty care, cultural and language barriers, stigma, and the lack of education about mental health and mental health resources. Regarding specific populations, the community is concerned about those who have experienced trauma, as well as youth, specifically LGBTQ youth. In addition, the community perceives a connection between domestic violence and drug/alcohol abuse, and community members expressed concerns about the lack of effective local substance abuse treatment services and facilities.

Note: The Community Benefit Advisory Committee and community benefit team acknowledged that mental health and substance abuse/tobacco use are conditions that often co-occur. "Behavioral health" is an umbrella term covering the full spectrum of mental health and substance use issues, including alcohol, tobacco, and other drugs.<sup>i</sup> By combining these two needs into one, the hospital can be more flexible in its approach to addressing either of these conditions separately, or addressing them concurrently. In addition, the team recognized that

---

<sup>i</sup> See the description of behavioral health integration from the Substance Abuse and Mental Health Services Administration, which is the U.S. Department of Health and Human Services' agency that "leads public health efforts to advance the behavioral health of the nation," at [www.integration.samhsa.gov/integrated-care-models/CIHS\\_quickStart\\_decisiontree\\_with\\_links\\_as.pdf](http://www.integration.samhsa.gov/integrated-care-models/CIHS_quickStart_decisiontree_with_links_as.pdf).

behavioral health is a driver of many other health issues and can make addressing physical health more difficult.

**Long-Term Goal: Improve behavioral health among residents in the Tri-Valley area.**

**Intermediate Goal B.1: Improve mental health and well-being among residents.**

**Goal B.1 Strategies:**

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Cognitive behavioral therapy (CBT), a therapeutic approach that attempts to solve problems resulting from dysfunctional thoughts, moods, or behavior through brief, direct, and time-limited structured counseling.<sup>17</sup> Can be effective for, e.g., reducing psychological harm from exposure to traumatic events,<sup>18,19</sup> post-partum depression.<sup>20</sup>
- Programs for educating community members in mindfulness-based stress reduction (MBSR) techniques to reduce depression and anxiety, and for stress management and pain management.<sup>21</sup>
- Programs for introducing mindfulness-based interventions (MBIs) in schools (for teachers and students) to address stress, coping, and resilience.<sup>22</sup>

Participate in collaboration and partnerships to address mental health in the community such as:

- Partnering with community behavioral health services organizations, task forces, or similar collaborations on efforts to address behavioral health in the community.

**Goal B.1 Anticipated Impact:**

- ◆ Increased knowledge among community members of methods of coping with stress and depression.

**Intermediate Goal B.2: Improve residents' access to coordinated mental health care.**

**Goal B.2 Strategies:**

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Supporting coordination of behavioral health care and physical health care, such as co-location of services (e.g., Axis Community Health).<sup>23,24</sup> Supported practices could include the following:

- Collaborative care for the management of depression using case managers to connect primary care providers, patients, and mental health specialists.<sup>25</sup>
- Clinic-based depression care management, including active screening for depression, measurement-based outcomes, trained depression care managers, case management, a primary care provider and patient education, antidepressant treatment and psychotherapy, and a supervising psychiatrist.<sup>26</sup>
- Staff-assisted depression care supports to ensure increased screening, accurate diagnosis, effective treatment, and follow-up.<sup>27</sup>
- Supporting providers or trained community members to screen for mental health issues (e.g., suicidal ideation, depression, and/or PTSD) among incoming ED patients and, where indicated, to make referrals to treatment.<sup>28</sup>

**Goal B.2 Anticipated Impact:**

- ◆ Among providers, increased knowledge of the importance of and approaches for routine screening and diagnosis of depression and related disorders.
- ◆ Improved clinical and community support for active patient engagement in treatment goal-setting and self-management.
- ◆ Improved access to mental health services among community members.

<b>Intermediate Goal B.3: Reduce drug and alcohol use among residents.</b>
--

**Goal B.3 Strategies:**

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Screening and behavioral counseling interventions in primary care for alcohol misuse.<sup>29</sup>
- Use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) or similar (e.g., Project ASSERT) practices to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. SBIRT-type practices take place in community health settings, such as clinics or emergency rooms, conducted by providers (SBIRT<sup>30</sup>) or trained community members (Project ASSERT<sup>31</sup>).
- Reduction of youth substance use and improvement in youth decision-making through programs such as “Every 15 Minutes”<sup>32</sup> or “Keepin’ it REAL.”<sup>33</sup>

**Goal B.3 Anticipated Impact:**

- ◆ Increased early screening and prevention.
- ◆ Increased knowledge among residents of the effects of illicit drug use and alcohol and prescription medication misuse.
- ◆ Increased knowledge of coping with stress and depression.
- ◆ Improved access to behavioral health services among community members.



### **C. Obesity, Diabetes, Healthy Eating, Active Living**

There are similarly high proportions of overweight residents in the VCSA compared to the state. In Alameda and Contra Costa Counties combined, half of both Whites and Blacks are overweight or obese, which is higher than the overall county proportions. A higher percentage of youth in the VCSA have low fruit/vegetable consumption compared to Alameda County and the state average. White youth in Alameda County are much more likely to have low fruit/vegetable consumption compared to Latino and Black youth. In the VCSA, a higher proportion of residents live in food deserts compared to the state average. There are fewer grocery stores and more fast food restaurants per capita in the VCSA compared to the state. In the VCSA, a higher percentage of the population has a commute over 60 minutes compared to the state. The amount of commute time can negatively impact other health-related activities (e.g., being physically active, sleeping, and preparing healthy meals). The community expressed concern about diabetes and diabetes management, access to open spaces/safe places to exercise, the expense of buying healthy food, and the need for more education about food resources. The community is most concerned about how the low-income population is impacted by this need.

**Long-Term Goal: Increase healthy behaviors among children, youth, and adults in the Tri-Valley area to manage, reduce, or prevent obesity and diabetes.**

**Intermediate Goal C.1: Increase healthy eating and active living among children, youth, and adults in the Tri-Valley area.**

#### **Goal C.1 Strategies:**

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Assisting schools in implementing guidelines for promoting healthy eating and physical activity, including but not limited to providing a quality school meal program and healthy eating choices outside of the meal program; employing qualified persons to provide physical education, health education, and nutrition services; and partnering with families to address healthy eating and physical activity.<sup>34</sup>
- Behavioral interventions aimed at reducing recreational, sedentary screen time among children and adolescents, and may also include interventions focused on increasing physical activity and/or improving diet.<sup>35</sup>
- Strategies to increase fruit and vegetable consumption, including but not limited to starting or expanding farmers' markets; support for including fruits and vegetables in emergency food programs such as food banks, food pantries, homeless shelters, emergency kitchens, etc.; ensuring access to fruits and vegetables in workplace cafeterias and other food service venues; improving access to retail stores that sell high-quality fruits and vegetables or increasing the availability of high-quality fruits and vegetables at retail stores in underserved

- communities; offering nutrition education on how to use/prepare and store fruits and vegetables.<sup>36</sup>
- In-kind support of community health workers (e.g., educators) for health education, and as outreach, enrollment, and information agents to increase healthy behaviors.<sup>37</sup>
- Exercise programs that help older adults increase strength, balance, and mobility.<sup>3</sup>
- Programs of education and support to assist older adults in self-management of their nutritional health.<sup>3</sup>
- Programs of education and support to teach new mothers methods of gaining energy, living a healthy lifestyle, and becoming motivated to take care of new families.<sup>38</sup>

Participate in collaboration and partnerships to promote healthy eating and/or active living such as:

- Tri-Valley Health Initiative, including health fairs for screening and education.
- All In to End Hunger 2020.

#### **Goal C.1 Anticipated Impact:**

- ◆ Increased knowledge about healthy behaviors.
- ◆ Increased access to physical activity.
- ◆ Increased access to healthy foods.
- ◆ Increased physical activity.
- ◆ Increased consumption of healthy foods.
- ◆ Reduced time spent on sedentary activities.
- ◆ Reduced consumption of unhealthy foods.
- ◆ More policies/practices that support increased physical activity and improved access to healthy foods.

#### **Intermediate Goal C.2: Improve diabetes management among adults in the Tri-Valley area.**

##### **Goal C.2 Strategies:**

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Diabetes self-management interventions in community gathering places,<sup>39,40</sup> including diabetes management education generally.<sup>3</sup>

##### **Goal C.2 Anticipated Impact:**

- ◆ Increased knowledge about diabetes and diabetes management.
- ◆ Improved diabetes self-management.

## **II. EVALUATION PLANS**

SHC-VC will monitor and evaluate the strategies described above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor will be tailored to each strategy and will include the collection and documentation of tracking measures, such as number of dollars spent, number of people reached/served, number and role of volunteers, and volunteer hours. In addition, SHC-VC will require programs to propose, track, and report outcomes, including behavior and health outcomes as appropriate.

## ENDNOTES

---

<sup>1</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, and U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Minority Health. (2009). *Pipeline programs to improve racial and ethnic diversity in the health professions: An inventory of federal programs, assessment of evaluation approaches, and critical review of the research literature*. Retrieved from <http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/pipelinediversityprograms.pdf>.

<sup>2</sup> Addresses HP2020 emerging health issue of “increasing the number and skill level of community health and other auxiliary public health workers to support the achievement of healthier communities.” <https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs>.

<sup>3</sup> Area Agency on Aging 1B. (2013). *Evidence-based disease prevention programs*. Retrieved from [www.aaa1b.org/wp-content/uploads/2012/05/List-of-Evidence-Based-Programs.pdf](http://www.aaa1b.org/wp-content/uploads/2012/05/List-of-Evidence-Based-Programs.pdf).

<sup>4</sup> U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National action plan to improve health literacy*. Retrieved from [http://health.gov/communication/HLActionPlan/pdf/Health\\_Literacy\\_Action\\_Plan.pdf](http://health.gov/communication/HLActionPlan/pdf/Health_Literacy_Action_Plan.pdf) (strategies include health library collections).

<sup>5</sup> Natale-Pereira, A., Enard, K. R., Nevarez, L., & Jones, L. A. (2011). The role of patient navigators in eliminating health disparities. *Cancer*, 117: 3541–3550. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1002/cncr.26264/full>; and Yates, P. (2004). Cancer care coordinators: Realizing the potential for improving the patient journey. *Cancer Forum*, 28(3):128-132. Retrieved from <http://eprints.qut.edu.au/1739/1/1739.pdf>; see also Brown, R. S., Peikes, D., Peterson, G., Schore, J., & Razafindrakoto, C. M. (2012). Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high-risk patients. *Health Affairs*, 31(6), 1156-1166. Retrieved from <http://content.healthaffairs.org/content/31/6/1156.full.html>.

<sup>6</sup> Centers for Disease Control and Prevention. (2005). *Controlling tuberculosis in the United States: Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America*. MMWR 2005; 54 (No. RR-12):1-81. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5412a1.htm>; also addresses HP2020 goal to “Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life,” <https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs>.

<sup>7</sup> Chazin, S. (2016). *Guiding innovations to improve the oral health of adult Medicaid beneficiaries*. Center for Health Care Strategies, Inc., January 2016. Retrieved from [www.chcs.org/media/Adult-Dental-Innovations\\_final2.pdf](http://www.chcs.org/media/Adult-Dental-Innovations_final2.pdf).

<sup>8</sup> Swarbrick, M. A., Jonikas, J. A., Yudof, Y., Kenny, M., Cohn, J., Serrano, C., & Cook, J. (2014). *Promoting wellness for people in mental health recovery: A step-by-step guide to planning and conducting a successful health fair*. Retrieved from [www.integration.samhsa.gov/health-wellness/wellness-strategies/UIC CSPNJ Health Fair Manual.pdf](http://www.integration.samhsa.gov/health-wellness/wellness-strategies/UIC_CSPNJ_Health_Fair_Manual.pdf).

<sup>9</sup> Centers for Disease Control and Prevention. (2016). *Addressing chronic disease through community health workers*. Retrieved from [www.cdc.gov/dhdsdp/docs/chw\\_brief.pdf](http://www.cdc.gov/dhdsdp/docs/chw_brief.pdf).

<sup>10</sup> Shealy, K. R., Li, R., Benton-Davis, S., & Grummer-Strawn, L. M. (2005). *The CDC guide to breastfeeding interventions*. Retrieved from [www.cdc.gov/breastfeeding/pdf/breastfeeding\\_interventions.pdf](http://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf).

<sup>11</sup> U.S. Department of Defense and U.S. Department of Veterans Affairs. (2009). *Clinical practice guideline for management of asthma in children and adults*. Retrieved from [www.healthquality.va.gov/guidelines/CD/asthma/ast\\_2\\_sum.pdf](http://www.healthquality.va.gov/guidelines/CD/asthma/ast_2_sum.pdf), pages 33 & 53.

<sup>12</sup> Guide to Community Preventive Services. (2009). *Increasing cancer screening: group education for clients*. Retrieved from [www.thecommunityguide.org/cancer/screening/client-oriented/GroupEducation.html](http://www.thecommunityguide.org/cancer/screening/client-oriented/GroupEducation.html).

<sup>13</sup> Underwood, J.M., Lakhani, N., Finifrock, D., Pinkerton, B., Johnson, K., Mallory, S.H., Santiago, P.M., & Stewart, S.L. (2015). *Evidence-based cancer survivorship activities for comprehensive cancer control*. Retrieved from [www.ajpmonline.org/article/S0749-3797%2815%2900485-7/pdf](http://www.ajpmonline.org/article/S0749-3797%2815%2900485-7/pdf); see also [www.cancersupportcommunity.org/publications-presentations](http://www.cancersupportcommunity.org/publications-presentations); and [www.cscpasadena.org/about-us/our-history/evidence-based-research](http://www.cscpasadena.org/about-us/our-history/evidence-based-research).

<sup>14</sup> Nakre, P. D., & Harikiran, A. G. (2013). Effectiveness of oral health education programs: A systematic review. *Journal of International Society of Preventive & Community Dentistry*, 3(2), 103–115. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4000911/>.

<sup>15</sup> Schwamm, L. H., Pancioli, A., Acker, J. E., Goldstein, L. B., Zorowitz, R. D., Shephard, T. J., & Gorelick, P. (2005). Recommendations for the establishment of stroke systems of care recommendations from the American Stroke Association's Task Force on the Development of Stroke Systems. *Stroke*, 36(3), 690-703. Retrieved from <http://circ.ahajournals.org/content/111/8/1078.full> (community education element).

<sup>16</sup> Centers for Disease Control and Prevention. (2006). *Prevention works: CDC strategies for a heart healthy and stroke-free America*. Washington, DC. CDC. Retrieved from [www.cdc.gov/dhdsdp/docs/prevention\\_works.pdf](http://www.cdc.gov/dhdsdp/docs/prevention_works.pdf); and Swor, R., Khan, I., Domeier, R., Honeycutt, L., Chu, K. and Compton, S. (2006). CPR training and CPR performance: Do CPR-trained bystanders perform CPR? *Academic Emergency Medicine*, 13: 596–601. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1197/j.aem.2005.12.021/abstract> (being CPR-trained is an important predictor in performing CPR as a bystander to a cardiac arrest).

<sup>17</sup> Examples of programs from SAMHSA's National Registry of Evidence-Based Programs and Practices include: <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=119> (Cognitive Behavioral Therapy for Late-Life Depression); <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=396> (Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT)); and



<http://legacy.nreppadmin.net/ViewIntervention.aspx?id=256> (Cognitive Behavioral Social Skills Training).

<sup>18</sup> Guide to Community Preventive Services. (2006). *Reducing psychological harm from traumatic events: cognitive-behavioral therapy for children and adolescents (individual & group)*. Retrieved from <http://www.thecommunityguide.org/violence/traumaticevents/behaviorthrapy.html>.

<sup>19</sup> Warshaw, C., Sullivan, C. M., & Rivera, E. A. (2013). A systematic review of trauma-focused interventions for domestic violence survivors. *National Center on Domestic Violence, Trauma, & Mental Health*. Retrieved from [http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2013/03/NCDVTMH\\_EBPLitReview2013.pdf](http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2013/03/NCDVTMH_EBPLitReview2013.pdf).

<sup>20</sup> Scope, A., Leaviss, J., Kaltenthaler, E., Parry, G., Sutcliffe, P., Bradburn, M., & Cantrell, A. (2013). Is group cognitive behavior therapy for postnatal depression evidence-based practice? A systematic review. *BMC Psychiatry*, 13(1), 1. Retrieved from <http://bmcpsy psychiatry.biomedcentral.com/articles/10.1186/1471-244X-13-321>.

<sup>21</sup> Chiesa, A. & Serretti, A. (2011). Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis. *Psychiatry Research*, 187(3), 441-453. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/20846726>; also, Zgierska, A., Rabago, D., Chawla, N., Kushner, K., Koehler, R., & Marlatt, A. (2009). Mindfulness meditation for substance use disorders: A systematic review. *Substance Abuse*, 30(4), 266-294. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/19904664>; and Marchand, W. R. (2012). Mindfulness-based stress reduction, mindfulness-based cognitive therapy, and Zen meditation for depression, anxiety, pain, and psychological distress. *Journal of Psychiatric Practice*, 18(4), 233-252. Retrieved from [www.ncbi.nlm.nih.gov/pubmed/22805898](http://www.ncbi.nlm.nih.gov/pubmed/22805898).

<sup>22</sup> Zenner, C., Herrnleben-Kurz, S., & Walach, H. (2014). Mindfulness-based interventions in schools—a systematic review and meta-analysis. *Frontiers in Psychology*, 5, 603. Retrieved from [www.ncbi.nlm.nih.gov/pmc/articles/PMC4075476/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4075476/).

<sup>23</sup> Unützer, J., Harbin, H, Schoenbaum, M. & Druss, B. (2013). *The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes*. Retrieved from <https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf>.

<sup>24</sup> Ginsburg, S. (2008). *Colocating health services: a way to improve coordination of children's health care?* (Vol. 41). New York, NY: Commonwealth Fund. Retrieved from [www.commonwealthfund.org/usr\\_doc/Ginsburg\\_Colocation\\_Issue\\_Brief.pdf](http://www.commonwealthfund.org/usr_doc/Ginsburg_Colocation_Issue_Brief.pdf).

<sup>25</sup> Community Preventive Services Task Force. (2012). *Recommendation from the Community Preventive Services Task Force for use of collaborative care for the management of depressive disorders*. Retrieved from [www.thecommunityguide.org/mentalhealth/CollabCare\\_Recommendation.pdf](http://www.thecommunityguide.org/mentalhealth/CollabCare_Recommendation.pdf).

<sup>26</sup> Guide to Community Preventive Services. (2008). *Interventions to reduce depression among older adults: clinic-based depression care management*. Retrieved from [www.thecommunityguide.org/mentalhealth/depression-clinic.html](http://www.thecommunityguide.org/mentalhealth/depression-clinic.html).

<sup>27</sup> U.S. Preventive Services Task Force. (2014). *Final recommendation statement: Depression in adults: Screening*. Retrieved from [www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening](http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening).

<sup>28</sup> Although it appears that no comprehensive evidence-based program of ED screening and referral for mental health issues currently exists [however, see this theoretical adaptation of the SBIRT model, expanded for triaging and intervening in suicidal behavior, especially Figure 1 and Table 1: Larkin, G. L., Beautrais, A. L., Spirito, A., Kirrane, B. M., Lippmann, M. J., & Milzman, D. P. (2009). Mental health and emergency medicine: a research agenda. *Academic Emergency Medicine*, 16(11), 1110-1119. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3679662/>], there is evidence that brief screening tools do well in detecting depression in older adult ED patients [Fabacher, D.A., Raccio-Robak, N., McErlean, M.A., Milano, P.M., Verdile, V.P. (2002). Validation of a brief screening tool to detect depression in elderly ED patients. *American Journal of Emergency Medicine*, 20:99–102], suicidal ideation among pediatric and young adult ED patients [National Institute of Mental Health. (2013). *Emergency department suicide screening tool accurately predicts at risk youth*. Retrieved from [www.nimh.nih.gov/news/science-news/2013/emergency-department-suicide-screening-tool-accurately-predicts-at-risk-youth.shtml](http://www.nimh.nih.gov/news/science-news/2013/emergency-department-suicide-screening-tool-accurately-predicts-at-risk-youth.shtml)], and PTSD among pediatric ED patients and their parents [Ward-Begnoche, W. L., Aitken, M. E., Liggin, R., Mullins, S. H., Kassam-Adams, N., Marks, A., & Winston, F. K. (2006). Emergency department screening for risk for post-traumatic stress disorder among injured children. *Injury Prevention*, 12(5), 323-326. Retrieved from [www.ncbi.nlm.nih.gov/pmc/articles/PMC2563451/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563451/)].

<sup>29</sup> U.S. Preventive Services Task Force. (2013). *Final recommendation statement: Alcohol misuse: Screening and behavioral counseling interventions in primary care*. Retrieved from [www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care](http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care).

<sup>30</sup> SAMHSA-HRSA Center for Integrated Health Solutions. (2011). *SBIRT: Screening, brief intervention, and referral to treatment*. Retrieved from [www.integration.samhsa.gov/clinical-practice/SBIRT](http://www.integration.samhsa.gov/clinical-practice/SBIRT); and Emergency Nurses Association. (2008). *Reducing patient at-risk drinking: A SBIRT implementation toolkit for the emergency department setting*. Retrieved from <http://www.integration.samhsa.gov/clinical-practice/reducing-patient-at-risk-drinking.pdf>.

<sup>31</sup> Boston University School of Public Health, The BNI ART Institute. (2012). *Project ASSERT: SBIRT in emergency care*. Retrieved from [www.bu.edu/bniart/sbirt-experience/sbirt-programs/sbirt-project-assert/](http://www.bu.edu/bniart/sbirt-experience/sbirt-programs/sbirt-project-assert/) and Rural Health Information Hub. (2016). *Rural mental health and substance abuse toolkit, evidence-based interventions for healthcare settings*. Retrieved from [www.ruralhealthinfo.org/community-health/mental-health/4/healthcare/evidence-based-interventions](http://www.ruralhealthinfo.org/community-health/mental-health/4/healthcare/evidence-based-interventions).

- <sup>32</sup> Bui, H., Arnold, L. S., Cooper, J. F., & Ragland, D. R. (2006). *Teens and driving in California: Summary of research and best practices*. Safe Transportation Research & Education Center. Retrieved from [http://safetrec.berkeley.edu/sites/default/files/Teens%20and%20Driving%20in%20Calif ornia.pdf](http://safetrec.berkeley.edu/sites/default/files/Teens%20and%20Driving%20in%20Calif%20ornia.pdf).
- <sup>33</sup> SAMHSA National Registry of Evidence-Based Programs and Practices. (2006). *Keepin' it real*. Retrieved from <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=133>; and Spoth, R., Greenberg, M., & Turrisi, R. (2009). Overview of preventive interventions addressing underage drinking. *Alcohol Research & Health*, 32(1), 53-66. Retrieved from <http://pubs.niaaa.nih.gov/publications/arh321/53-66.pdf>.
- <sup>34</sup> Centers for Disease Control and Prevention. (2011). *School health guidelines to promote healthy eating and physical activity*. MMWR 2011; 60 (No. RR-5):1-76. Retrieved from [www.cdc.gov/mmwr/pdf/rr/rr6005.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr6005.pdf).
- <sup>35</sup> Guide to Community Preventive Services. (2014). *Obesity prevention and control: behavioral interventions that aim to reduce recreational sedentary screen time among children*. Retrieved from [www.thecommunityguide.org/obesity/behavioral.html](http://www.thecommunityguide.org/obesity/behavioral.html).
- <sup>36</sup> Centers for Disease Control and Prevention. (2011). *Strategies to prevent obesity and other chronic diseases: The CDC guide to strategies to increase the consumption of fruits and vegetables*. Atlanta: U.S. Department of Health and Human Services. Retrieved from [www.cdc.gov/obesity/downloads/FandV\\_2011\\_WEB\\_TAG508.pdf](http://www.cdc.gov/obesity/downloads/FandV_2011_WEB_TAG508.pdf).
- <sup>37</sup> Guide to Community Preventive Services. (2015). *Cardiovascular disease prevention and control: Interventions engaging community health workers*. Retrieved from [www.thecommunityguide.org/cvd/CHW.html](http://www.thecommunityguide.org/cvd/CHW.html).
- <sup>38</sup> Healthy Start EPIC Center. (2015). *Evidence-based practices: postpartum care* (<https://medlineplus.gov/postpartumcare.html>). Retrieved from <http://healthystartepic.org/resources/evidence-based-practices/postpartum-care/>.
- <sup>39</sup> Guide to Community Preventive Services. (2001). *Diabetes prevention and control: Self-management education*. Retrieved from <http://www.thecommunityguide.org/diabetes/selfmgmteducation.html>.
- <sup>40</sup> Missouri Department of Health and Senior Services. (Undated). *Community health improvement resources: Diabetes*. Retrieved from <http://health.mo.gov/data/InterventionMICA/Diabetes/1522.pdf>; see also Two Feathers, J., Kieffer, E.C., Palmisano, G., et al. (2005). Racial and Ethnic Approaches to Community Health (REACH) Detroit partnership: Improving diabetes-related outcomes among African American and Latino adults. *American Journal of Public Health*. September 2005, 95(9):1552-1560.